DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99 — 03

2. STATE: KY

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
4/1/99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.271
1923(g) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 89 $ 17.5 million
b. FFY 00 $ 17.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page ~~8~~ 10
Attachment 4.19-A, Page ~~9~~ 11
Attachment 4.19-A, Exhibit A, page 102B.03

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 8
Attachment 4.19-A, Exhibit A, page 102B.03

10. SUBJECT OF AMENDMENT:
Payments for Inpatient Hospital SErvices

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner Dept for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:
Policy Coordination Branch
Department for Medicaid SErvices
2275 East Main Street
CHR Bldg - 6th Floor East
Frankfort KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 29, 1999

18. DATE APPROVED:
DEEMED APPROVED — March 2, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

(12) Intensity Operating Allowance Inpatient Supplement.

During the final quarter of SFY 1999, instead of the additional payment amount provided for under Section (5)B.2 of this attachment, any qualifying hospital that meets the additional criteria of a Type III hospital as described in Attachment 4.19-A, Exhibit A, Section 102B.(d) (3), shall receive a supplemental payment for the current rate year. This supplement shall be an amount established according to the following method and shall be distributed to qualifying hospitals as described below.

A qualifying hospital's pediatric teaching supplement =
2% of the per diem rate X Medicaid utilization rate X Medicaid patient days.

Medicaid utilization rate for the above calculation is the rate derived by dividing a hospital's total Medicaid days by the total patient days. *Medicaid patient days* include days reimbursed through a managed care entity and the fee-for-service reimbursement methodology.

Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

Subsequent payments made under this section shall be prospectively determined quarterly amounts and shall be subject to the same limitations and conditions as above.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

13) Payment Not To Exceed Charges

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges-plus-disproportionate share.

14) Limit on Amount of Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. The amount of disproportionate share payments that exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Section 1923 (g) of the Social Security Act.)

Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments. If payments exceed costs, the financial gain from Medicaid will not be applied against the unrecovered cost of uninsured/indigent patients.

Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. If payment exceeds cost, the financial gain will not be applied against the Medicaid payment shortfall. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

SECTION 102B. DISPROPORTIONATE SHARE HOSPITALS

(2) State university teaching hospitals having Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of paid Medicaid days shall have an upper limit set at 126 percent of the weighted median per diem cost for hospitals of 401 beds or more. Any state designated pediatric teaching hospitals shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective, reasonably determined uncompensated Medicaid cost to the facility. For the rate year ending June 30, 1999, any state designated state pediatric hospital further meeting the qualifications of a Type III hospital, instead of the above, shall be paid a supplemental payment in an amount equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the Medicaid charges of the hospital. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid, if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A).